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Casualty of Peace: The Army Medical Department in 2003

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**CASUALTY OF PEACE:
THE ARMY MEDICAL DEPARTMENT IN 2003**

HARLAND G. LEWIS, JR.

ABSTRACT

This paper uses the format of a hypothetical congressional response to provide a vision of the U.S. Army Medical Department (AMEDD) in the year 2003. The author foresees an AMEDD structured as a primarily civilian, catchment area management system to support nonactive duty beneficiaries with a parallel, wartime requirements-based structure to provide health care for active duty forces. The author argues for creation of deployable, embedded tactical health care units (ETUs) and a unified health command (HEALTHCOM) in the continental United States (CONUS) to plan and coordinate contingency health care to support the overseas unified commanders in chief (CINCs).

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The Army Medical
Department in 2003**

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Casualty of Peace: The Army Medical Department in 2003

HARLAND G. LEWIS, JR.

The author structures this article as a hypothetical congressional, written in response to a complaint by a family member of an active duty service member who returns to the continental United States (CONUS) in the year 2003. The family member complains of not receiving comprehensive health care solely from military treatment facilities--as experienced while overseas and before departing CONUS in 1993.

The article begins with a summary of our current national security situation, and following this analysis, describes a possible Army Medical Department existing in 2003.

Accordingly, the thoughts contained in this scenario are totally those of the author and do not represent official Army policy.

I. Introduction

My Dear Constituent,

Thank you for this opportunity to explain why the military health care system you remember in CONUS has changed. I understand why you miss the simplicity and convenience of the old system, but the world changed dramatically while you were overseas, and the Army Medical Department (AMEDD) could not remain the same. I hope after reading this letter, you will agree with me that while different, the AMEDD of 2003 remains a strong and capable organization.

So let me begin. As a point of reference, I'll first go back and summarize our national security situation in 1993. Then, I'll follow the course of events that led us to the creation of the AMEDD we have today.

II. The Situation in 1993

The World

Perhaps dramatic change in the world really began in 1989. As you remember, that was the year when a few Germans climbed the Berlin wall, and to their pleasant surprise, were not shot! The wall came down, and after 40 long years, the two Germanys were reunited. Events then proceeded at a rapid pace. The Baltics bravely proclaimed their independence. The Soviet Union disintegrated into a collection of republics. The Cold War was over, the West's strategy of containment had won and President Bush, justifiably proud, proclaimed the beginning of the "New World Order."

Some characterized this new order as "dead on arrival." A *stable* new world just never got started. First, there was Operation Desert Storm. We defeated Saddam Hussein's army, but he continued to give us problems. Regional instability in the Middle East continued with open Arab-Israeli conflict and Palestinian homeland issues. Overpopulation, economic stagnation and the loss of skilled workers, managers and leaders due to the AIDS epidemic burdened the sub-Saharan African region. We saw the Asian states, especially Japan, Korea, and Greater China, become even greater economic powers while historic, territorial tensions continued. Massive changes took place in Europe and the former Soviet republics. The European Community countries continued to gain economic power, although without significant political union. The Balkan states managed to compromise enough to avert another full-scale European war, but ethnic tensions and refugee migration

problems remain. Closer to home, the situation in Latin America has improved considerably. The flow of illegal drugs remains a problem, but we have seen growing political stability and diminishing economic crises, especially with maturation of the North American Free Trade Agreement.

Besides these regional events, in 1993 we also saw some international trends. We began to question the relevance of certain U.S. security alliances in the multipolar environment. Regional economic cooperation increased, concurrently with global economic competition and interdependence. Humanitarian and environmental organizations, the United Nations and multinational corporations all grew in power and importance. The growth of technology facilitated international communication and information exchange, and ominously, the proliferation of weapons of mass destruction. There was also increasingly intense competition for the world's limited natural resources.

We translated these events and trends into some long range predictions. There would be global diminution of national sovereignty and increased disparity between the "haves" and "have-nots." Environmental issues and ethnic rivalries would continue to be increasing sources of international tension. Lastly, technology and education would play increasing roles in national power.

Our Security Strategy

In response to this rapidly changing world, we implemented our 1993 National Security Strategy.¹ This strategy was based on our core values of freedom, survival, prosperity and peace,

supporting respectively, our ideological, defense, economic and political national interests and objectives.² Our political aim, called "Vision 2003," guided us in this process and states: "The United States will be the leader of a world system that promotes freedom, prosperity and peace."

Our defense, economic, and political policies provided the power for our security strategy. We realized our national security would ultimately depend on our domestic strength. We could only afford minimally sufficient strategic forces. Arms control, collective security, focused intelligence and flexible military forces would be essential. We had to reduce the government deficit by enhanced investment for sustained economic growth. Free trade, support to developing nations, global environmental responsibility and national energy policy were all important issues. We would remain politically engaged by supporting democracies, maintaining beneficial alliances, and providing benevolent humanitarian but commercially purposeful military, economic, and educational assistance. We concluded that, even with growth in alliances, there was no acceptable substitute to U.S. world leadership--and it would be costly. All our actions would be resource constrained.

III. Our Military In 1993

Even with this unsettled strategic situation, many began to ask: "With the breakup of the Soviet Union ending the Cold War, why do we need such a large military and what is its role?" The answer was that our military could be smaller and that its role

in our society and the world would change considerably.

To begin, let's go back to the 1992 presidential election. President Clinton won on a mandate for change, especially to improve our national economy. There was pressure to reduce the federal deficit, and military expenditures were a less politically painful target of opportunity.

As a starting point, President Clinton inherited a plan that proposed a restructuring of our military forces from post-Desert Storm (1991) levels to what was known as the Base Force. This force not only specified numerical strengths, but it also defined our national military strategy: provide a capability to deter aggression, provide meaningful presence abroad, respond to regional crises, and if necessary, rebuild a global warfighting capability.³ The Base Force would perform these roles by maintaining adequate nuclear capable forces, forward presence overseas in regions vital to our national interests, a core of "lethal" forces ready to deploy to specific regions, and if the problem was more than we anticipated, the potential to rebuild or reconstitute additional forces.

While its authors believed the Base Force acknowledged the "changing world order and domestic fiscal constraints,"⁴ the incoming Secretary of Defense Les Aspin did not fully agree. He preferred a smaller force package called "Option C,"⁵ but reductions in our forces continued beyond 1995 to levels even lower than he had first expected.

The real debate and change in thinking came not with numbers, but with the roles and missions of our military forces. Nobody

seriously questioned that our Army's principal role was to fight and win America's battles.⁶ However, there were different kinds of "battles" facing America in 1993: decaying infrastructure, falling educational achievement, rampant crime, abuse of illicit drugs, environmental crises and periodic natural disasters. Internationally, there was a plethora of problems awaiting resolution: regional conflict, natural catastrophe, illiteracy, hunger and disease.

Some of our leaders envisioned the U.S. military as an educated, trained and highly motivated, value oriented, and in their mind, underutilized resource available to apply to these problems. Senator Nunn argued that the US military has "a proper and important role" in battling these domestic problems.⁷ Secretary of the Army Stone said, "the downsized Army should be able to handle those operations and its traditional national defense role."⁸ Several specialists told a Senate subcommittee that the military should be given a much greater role in the handling of natural catastrophes, even taking over some functions of the Federal Emergency Management Agency (FEMA).⁹ Secretary Aspin even restructured DoD to strengthen its role in what his aides termed "the security problems of the 1990s," to include nuclear security and counterproliferation, economic and environmental security, and democracy and human rights.¹⁰

History does provide many positive examples of the use of military forces in these non-traditional roles (NTRs). The U.S. military was active with the initial exploration and development of the West, anti-slavery patrols, reconstruction

of the South, supervision of the Civilian Conservation Corps, desegregation of public schools, peacekeeping in the Sinai, drug interdiction, humanitarian relief to Bangladesh and Somalia, and many more NTRs.¹¹ The AMEDD, with its expertise in public health and treatment of mass casualties, has an impressive record of support to civilians during natural disasters, famines and epidemics.¹² Brehm and Grey noted that it is only since World War II that the public has perceived the Army as essentially a combat force.¹³

The NTRs awaiting execution by our military in 1993 included: environmental issues, crime prevention, educational assistance, weapons antiproliferation, antiterrorism, drug control, chemical decontamination, health care to underserved areas, humanitarian assistance, disaster relief and a host of other civic action programs. One author even suggested creation of a military "US Rescue Force," instead of FEMA, to deal with national emergencies.¹⁴ In this era, "provide for the common defense" meant far more than just fighting wars.

Some authorities cautioned against greater involvement by today's military in performing these NTRs. They feared that any significant diversion from its military mission would cause our forces to lose their qualitative edge in combat. There was considerable resistance to our military performing civic projects, which diminished opportunities for civilian business.¹⁵ Others feared that a military performing NTRs would become just another governmental agency, subject to massive reduction or elimination. In Parameters, Dunlap portrayed

perhaps the greatest risk of military involvement in NTRs when he postulated a complete takeover by the military of an ineffectual civilian government in the year 2012.¹⁶

Few disputed that even in this unpredictable era, that our military must keep its combat focus. It is not time "to turn our carriers into hospital ships."¹⁷ Since we are no longer facing a single threat, our strategic task, as quoted from the Wall Street Journal in 1993, is "to promote stability, peace and prosperity in an era of political fragmentation and social upheaval."¹⁸

I hope this gives you some appreciation of the forces and pressures facing our military in 1993. Let us now focus on health care.

IV. U.S. Health Care in 1993

Kosterlitz described U.S. health care in 1993 as "A Sick System."¹⁹ She elaborated four problem areas:

- Soaring Expenditures: Americans spent more than \$800 billion for health care in 1992, representing 14% of GNP, and costs were rising at more than 10% annually.
- Lack of Coverage: About 36 million Americans were without health insurance, while another 20 million had inadequate coverage. Those without coverage typically received poorer quality care, often neglecting preventive procedures resulting in more expensive treatment later.
- Costs to Companies and Workers: Businesses complained

that health costs were crimping profits and eroding competitiveness. Workers complained of no growth in spending power.

- Gaps in Delivery: The system favored costly cures instead of prevention, trained too many specialists and didn't adequately serve inner-city and rural areas.

There was tremendous disagreement on the specific steps required, but consensus emerged on three broad objectives:

- Universal insurance protection and subsidies for the poor
- Consumers should have a choice of health care plans
- Endorsement of the managed care concept

These forces and changes in national health care in 1993 also affected the AMEDD. For many reasons, it became impossible at almost every location to provide health care solely from military facilities. The AMEDD in 1993 was following the principles of DoD's Coordinated Care Program, known as Gateway to Care (GTC). The stated goal of GTC was "to improve access and the quality of care for its beneficiaries through physician oversight, improved clinical access, early intervention, and a network of cost effective specialty providers, both federal and civilian."²⁰

In effect, that meant that your military hospital or clinic was networking with other facilities, local and distant, military and civilian, so that each could use its resources most efficiently. Similar to the civilian sector, the federal government could just no longer afford the costs of excessive and inefficient health care.

V. Toward the New AMEDD

It was in this challenging and uncertain world of 1993 that our leaders made some difficult decisions. Fundamental to change in the AMEDD was the decision to reduce the size of our military forces. In FY 91, AMEDD personnel accounted for 8.9% of Army active duty strength, and under the initial Base Force target levels, would have increased to 9.7% of the active strength by FY 95.²¹ Many felt that these AMEDD force levels were simply too high. The result was that in 1993, the Army Chief of Staff issued directive guidance to the Surgeon General to reduce the active duty strength of the AMEDD to the minimum level consistent with its mission. Concurrent with this reduction, the quality of care must not be diminished. Finally, the AMEDD should strive to reduce, not just shift to other payers, the costs of the health care it provides.

That guidance set forth a process of change that still continues. There were three specific requirements contained in the Chief's guidance: attain minimal active duty strength, maintain quality and reduce costs. We restated each of these requirements separately to determine their implied tasks.

To calculate our "minimal active duty strength," we went back to the basics--to determine or confirm the basic reasons for the AMEDD's very existence. We decided that the reasons, or missions, stated in the AMEDD's 1992 Long Range Plan were still valid.²² The Plan states that the AMEDD must:

- Maintain the health of the Army and conserve its fighting strength.

- Provide, concurrently with its other functions, health care for eligible beneficiaries in peacetime.

- Prepare for health support to the Army in time or war, international conflict, or natural disaster.

The key initial discussions centered on reducing active duty strength levels. The central question was this: Which of these functions contained in the Long Range Plan could be done only by active forces? We reaffirmed that medical support to the Army's combat mission certainly required active forces. Remember, this was the era of "cooperative engagement,"²³ forward presence, power projection, and "versatile mobile forces."²⁴ This orientation resulted in frequent use of our Army for tasks that would not be done by civilian organizations. Second, we still had many soldiers and some families stationed overseas and in remote US locations where quality health services were simply not available from local civilian sources. Beyond these two end-result functions, the requirements for using primarily active AMEDD forces became far more limited.

As for "maintain quality," we focused on what quality means from the patient's perspective: simplifying access to care, reducing the sometimes bureaucratic, impersonal nature of the *process* of obtaining health care, and ensuring the quality of services was equal to or better than those provided to other residents in the surrounding community. Quality in the readiness perspective meant that our active duty providers must not *only* be capable of performing quality care in a tactical environment, but also must ensure that supported commanders

know that we can. This requirement begins with our doctors, who must also be trained as professional soldiers.

To "reduce costs" we had to ensure our health care leaders had the authority and required infrastructure commensurate with their responsibility for controlling costs. Since the military has some cost-reducing, regulatory advantages over civilian health care systems, we strove to maximize the *control* of health care for our mandated beneficiaries. To avoid shifting costs, we needed the capability to identify our patient population *by-name* and location of residence. Finally, to reduce costs we knew that we needed the financial or command-directed power to mandate proven, cost-reducing preventive health care procedures for our beneficiaries.

VI. The New AMEDD

This guidance, issued in 1993, caused many changes that you see 10 years later in the AMEDD today. The basic thrust of these changes was to civilianize the AMEDD in CONUS, except for the capability required to support its deployment mission. Let me summarize these changes under three broad topics, which I'll discuss individually:

- Catchment Area Management
- Embedded Tactical Units
- Command and Control

Catchment Area Management (CAM)

I'm sure you remember President Clinton's focus on national health care reform. This was a *big* political issue because our country simply could no longer afford the runaway costs of its health care system, estimated in 1993 to exceed \$1.6 trillion by the year 2000.²⁵ The Military Health Service System (MHSS) was a major participant in the reform process. The FY 91 expenditures for the MHSS were \$15.1 billion,²⁶ about 2% of total expenditures spent for U.S. health care.²⁷

There are many reasons why the costs for health care were rising so fast.²⁸ The expanding availability and coverage of health insurance over the past 50 years have fueled consumption, but shielded consumers and providers from the actual costs. Use of health care has risen with our aging population. In 1993, we paid for the inefficiency resulting from more than 1,500 different private health insurance plans. Finally, there were the rising costs associated with fraud, excessive litigation, unnecessary care, and the new, more sophisticated technologies, drugs and procedures.

To address these problems, President Clinton decided to support the managed competition plan. As you know, this model groups workers and retirees into huge community-based insurance pools. Under this idea, consumers shop for the plan that best fits their needs, reducing costs as the various plans compete with each other. In turn, these plans control their costs by placing limits on services provided and fees or salaries paid to participating providers.

The military version of managed competition is our Catchment Area Management (CAM) system. Long ago we reached a point where the military facilities, by themselves, simply couldn't provide all the health care demanded by its beneficiaries. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) helped distribute this demand, but costs rose concurrently with the Program's maturation. The increase in the proportion of soldiers with families and in the number of retirees has also increased demand and costs for military health care. The services adopted the CAM system in an attempt to enhance access, improve quality and control costs. Here's an abbreviated summary of how it works.

First, all active and reserve component personnel living within a CAM's specified geographic region are involuntarily enrolled, with optional enrollment offered to other eligible beneficiaries of the MHSS. The catchment commander then establishes a network of health care capability to support the needs of the catchment population. This network will include the regional military facilities and civilian providers necessary to provide the care expected for the enrolled population.

Active duty health care personnel are allocated to the strength necessary to provide the care required by the supported, deployable active duty forces. For example, at posts with large numbers of deployable soldiers, you will find active duty personnel trained to provide the full range of health care, except perhaps for the specialty care not required by forces during deployment. This specialty care is provided by a network

of civilian providers--CHAMPUS, CHAMPUS partners, Delta Dental, contract, PRIMUS clinics, MEDCEN referral, government civilian employees--whatever works best for the patient at the particular location.

Since there is a known, supported population, CAM can really use its primary care capability to enhance access and reduce costs by emphasizing preventive care and controlling specialty referrals. Periodic medical and dental examinations are mandatory for all military personnel, active and reserve component, and encouraged for all other enrollees. The regional commander carefully monitors the quality of care and has the authority to remove substandard providers from the system. An expanded civilian administrative staff enables active duty personnel to participate in their readiness role, the second aspect of the new AMEDD.

Embedded TOE Units (ETUs)

The ETU concept is not new to the AMEDD, but it is somewhat new to CONUS. The ETU system consists of active duty, deployable tactical (TOE) units existing or embedded within the larger, community medical or dental organizational structure. The ETU system is analogous to the structure existing within the Army's medical command in Europe.

Both Operation Desert Storm (ODS) and the reduction of Army forces in Europe provided the impetus to establish this system in CONUS. Many tactical health care units deployed from Europe to support our forces in ODS. When these units disbanded with the European drawdown after ODS, the Army's lost much of its active

force capability to provide *area support* health care. To correct this loss of contingency capability, in 1993 we began to create ETUs in CONUS.

The drawdown from Europe gave us an ideal opportunity to change our structure--and we took advantage of it! In a somewhat visionary effort, we had previously created the force structure used in the ETU concept when we modernized the AMEDD under the Medical Force 2000 (MF2K) initiative.²⁹ The MF2K structure allowed us to use a "building block" approach in creating our TOE medical forces. Each "block" represents a specific health care unit and function that can be combined in packages tailor-made for the needs of the particular contingency. This capability is especially useful for building the smaller, area support force packages that were lacking in the active force structure in CONUS. These area support medical, combat stress control, dental, veterinary and preventive medicine units have been especially useful in this new strategic era.

We built these ETUs at locations with existing active duty health care personnel, avoiding the substantial expenses caused by unit relocation. Using MF2K structure, we created the larger ETUs at posts which have a large number of deployable soldiers--posts which therefore require more numerous and specialized health care personnel. The ETUs created were generally those required, using established basis of allocation rules, to provide health care for the supported force when deployed during a contingency. The community's peacetime health care requirements determined the ETU's authorized level of

organization (ALO). We used active duty health care personnel within the local Army medical center (MEDCEN), medical activity (MEDDAC) or dental activity (DENTAC) to staff each ETU to the highest ALO possible.

The ETUs are documented units, each with all authorized equipment and assigned personnel on site. When a headquarters was required, it was created--to include the commander or team leader and the supporting administrative and logistical personnel. The CAM and ETU systems were structured so that if the supported active duty soldiers deployed from home station, the ETUs could go with them, with minimal adverse impact to the health care provided to the remaining beneficiaries. This small unit, ETU "building block" concept avoided the significant problems faced by the Navy in staffing the huge 1000 bed hospital ships, USNS Comfort and Mercy, largely with personnel from their medical centers at Bethesda and Oakland, respectively.

We could not create a perfect capabilities "crosswalk" between the wartime-requirement generated, ETU forces and the community peacetime health care structure. There are geographical disparities. For example, an Army medical center might exist on a post with few deployable combat forces. This medical center performs neurosurgery and therefore could provide an ETU neurosurgery team. However, the basis of allocation does not justify the requirement for this team solely to support the deployable forces on post. These local imbalances largely disappear when viewed from a CONUS-wide perspective. We created, from within the peacetime active duty structure, almost all the

health care TOE units required to support the active duty, CONUS based contingency combat forces.

Command and Control (Figure 1)

To address command and control, let's start at the bottom of the command pyramid and work toward the top:

First, command of the ETUs. What seemed like a clear cut decision was instead, an issue of heated debate. The choices were to place the ETUs under command of either the regional MEDCEN, MEDDAC or DENTAC, or under U.S. Army Forces Command (FORSCOM). Granted, ETU personnel must spend some time performing readiness activities instead of patient care. However, the determination of time allocation between these functions must be made by the *local* health care commander. This is the system of command used by our medical units in Europe--and it works well.

Command of the entire health care structure at community or regional (CAM) level remains with the appropriate MEDCEN, MEDDAC or DENTAC. The concept of giving command authority to the leaders of community health care organizations has proved its merit over time. It is the principal reason for our success.

The U.S. Army Medical Command, established in 1994, now commands all CONUS, Army health care units, reserve and active component at echelons above corps. In the 1990s, the reduction of active forces and frequent activation of reserve forces diminished the distinction between the active and reserve components. Health care is a *system*, and in this complex strategic era, our national leadership realized that the

efficient and coordinated employment of area support, CONUS health care forces required a single commander.

Perhaps the biggest change in military health care command came with the establishment of a unified Health Care Command (HEALTHCOM) in CONUS similar to the U.S. Transportation Command. The idea of a joint health command in CONUS was not new. Soon after creation of DoD in 1947, the Hall Board recommended formation of a joint medical contingency element at the Joint Chiefs of Staff level to serve as the Services' focal point for input of joint medical planning and policy.³⁰ Since that board, there have been at least 23 other committee reports, studies, or directives addressing consolidation of the military health service system.³¹ Until 1993, the Services largely resisted all attempts toward CONUS-level, operational consolidation. There were examples of local, personality-based cooperation among certain hospital commanders, but each Service was reluctant to give formal command or even operational control of its health care organizations to another Service. This resistance caused peacetime care and contingency preparation inefficiencies that our country could simply no longer afford. The Services finally realized that they either had to establish a CONUS-level, unified health command to take charge of their operational destiny or Congress would create a civilian health agency to do it for them.

The real impetus to create a unified health command in CONUS came with the designation, in 1993, of the unified Atlantic Command (LANTCOM) to serve as "CINC Americus."³² In this role,

LANTCOM was responsible for coordinating joint training, policy and operational planning for the CONUS-based contingency forces. As you know, these forces have been very active, both at home and abroad, in response to the many, diverse challenges to our national security. The creation of HEALTHCOM provided the essential, single point of contact to coordinate health care support--for both peacetime care in CONUS and contingency planning in support of our overseas CINCs.

VII. An Example, Fort X:

Now that I've described the new AMEDD in broad terms, let me use an notional example to help show the resulting health care structure. Our post will be in CONUS, near a medium-sized city included within the catchment area boundaries. The CAM's enrolled population includes the post's two combat brigades, their supporting units, other active duty soldiers supporting the post's operation, soldiers assigned to reserve units within the catchment, and participating retirees and family members.

Both active duty and civilian personnel provide the full spectrum of health care for this population. Active health care forces include those organic to the combat forces and soldiers assigned to the MEDDAC and DENTAC and those assigned to the ETUs. Using established basis of allocation rules, planners create an appropriate mix of MF2K units to support the two brigade force when it deploys. Personnel authorized within the MEDDAC and DENTAC staff these ETUs to the maximum ALO possible.

Civilian health care personnel provide most of the health

care services for the catchment enrollees, except those services performed by health care personnel assigned to the combat units and ETUs. Therefore, when the brigades deploy, the ETUs can go with them--or deploy somewhere else. This structure minimizes the adverse impact to the health care for the catchment's remaining beneficiaries.

VIII. Advantages

The new AMEDD offers at least five categories of advantages over the old system: enhanced readiness, increased capability, enhanced esprit de corps, economy of force and unity of command.

Enhanced Readiness

The CAM system enhances the readiness of the total Army because it includes reserve component personnel and focuses on prevention. Perhaps improvement of the total force's dental readiness was the greatest health care benefit gained from including reserve forces in the CAM system. During mobilization of forces for Operation Desert Storm, King noted that Army reserve component soldiers were two to three times more likely than their active counterparts to require treatment to reduce the risk of dental emergencies.³³ Performing mandatory preventive health measures during peacetime provides more time for reserve component soldiers to conduct mission essential training upon arrival at mobilization station.

The ETU system provides a ready force of active duty, deployable, area support health care units, avoiding the problems that would result from frequent callup of reserve component

health care providers.³⁴ The ETUs do not have to deploy with the unit they support in garrison. Instead, the ETUs could deploy to a different location or remain on post and provide patient care for other catchment beneficiaries, conduct readiness training or perform other non-patient care activities.

The ETUs can conduct realistic training since they locally maintain their full authorized level of equipment. They also can use their deployable equipment in affiliation with civilian organizations to gain valuable experience performing urban, combat-related, emergency medical care procedures.

Serving as the single command point of contact for Army health care in CONUS, the Army MEDCOM greatly increases readiness by coordinating the transition to deployment for both the ETUs and reserve component health care units.

In summary, as we downsized our forces during the 1990s, the importance of readiness increased for those units that remained. Optimal readiness would not have occurred without these substantial structural and command changes to the military health care system.

Increased Capability

In 1993, our military forces were largely organized, manned and equipped for European reinforcement. We recognized the need to shift our focus, but there was disagreement on how this should be done. Secretary Aspin stated that we must structure our forces to a "concrete estimate of potential threats to U.S. interests,"³⁵ but no one could predict with a high degree of certainty, the full range of future challenges to our national

security. This dilemma led to the development of a capabilities-based force structure. Using this idea, we projected the operational tasks required for future contingencies and developed supporting health care forces.

Our ETUs provide a proper appreciation for this uncertainty. These units are flexible, mobile and truly ready for short notice deployment. Their modular structure simplifies task organizing for unanticipated contingencies. They are perfect for use in non-traditional, health care roles in support of our national security policy.

Enhanced Esprit de Corps

The ETU system enables soldiers to experience the pride, camaraderie, discipline and esprit de corps that occurs with hard training for a realistic tactical mission. Readiness training also encourages development of leadership skills, which are otherwise comparatively limited for female soldiers and for all lower ranking officers and NCOs with health care specialties. Finally, the observable attainment of true readiness capability engenders genuine respect from the supported line commanders.

Economy of Force and Unity of Command

This co-advantage has two aspects: economy of force gained from creation of ETUs and the benefits of a unified HEALTHCOM.

ETUs provide deployable health care capability at minimal cost and bridge the readiness gap between reserve component health care forces and those organic to supported units. The unified HEALTHCOM:

- Coordinates CAM-based, peacetime military health care

system in CONUS.

- Facilitates the efficient employment of deployable medical forces during operational contingencies.
- Reduces duplication of deployable, health care capability among all the services.
- Establishes priorities for the allocation of operational resources.
- Places the functions of patient regulating, blood and medical intelligence under a single health care commander.

IX. Potential Disadvantages

There are at least two potential disadvantages arising from the new AMEDD structure: reduced opportunity for specialty training and excessive cost. In this section, I will discuss these issues and explain why they may not be as negative as first perceived.

Reduced Opportunity for Specialty Training and Education

At most catchment locations, the new AMEDD structure authorizes active duty providers only for those health care specialties required to support the deploying forces. This change reduced the system-wide requirements for active duty providers in certain specialties. However, some overseas and isolated CONUS locations still require active duty officers from all the principal health care specialties to provide the full spectrum of services. Also, the increased emphasis on primary care created more requirements for specialists performing those services. There was still a requirement to train active duty

health care personnel for selected, service-unique specialties. Each catchment headquarters continues to sponsor a full range of specialty topics during its continuing health educational programs. Opportunities for training in language, cultural or political disciplines may arise if ETUs focus on operation within specific geographic regions. We may choose to augment accession-enhancing medical programs to include the Uniformed Services University of the Health Sciences and scholarship programs. We may even decide to subsidize specialty training for civilian doctors in return for a subsequent term of employment. In this era of managed health care organizations, officers leaving the service to pursue specialty training may later decide to return to the known comfort of the value-based, military health care system.

Excessive Cost

The ETU system will detract from catchment health care productivity to the extent that ETU personnel participate in readiness training. However, in this uncertain strategic era we simply had to free ourselves from the paradigm that prudent readiness training is not affordable.

We implemented the ETU system smartly. First, we studied how Canada provides health care for her military family members. We learned valuable lessons for our ETU concept from critique of the U.S. Air Force Air Transportable Hospital system. Finally, we established ETUs at a single site and then expanded CONUS-wide.

Learning from these studies, we found it necessary to reevaluate the basis of allocation rules. The benefits of

enhanced, pre-deployment individual preventive care reduced the demand for ETUs providing these services. Employment of the ETU system required realistic adjustment to DoD productivity based staffing standards. Without this relief, ETU commanders were reluctant to allocate the time necessary for adequate deployment training. However, the efficiency gained by civilianization of the remaining catchment health care structure more than compensated for comparatively small loss of productivity experienced by the ETU system.

Other factors helped reduce total costs. A stable civilian staff can more efficiently perform the time-intensive manipulation of data required for quality assurance and utilization management programs. We strengthened and closely monitored the "gatekeeper," primary health care system, to attain the related goals of enhancing access and controlling specialty referrals. Creation of ETUs enabled us to reduce the number of reserve component health care units. We reduced the training requirement for selected ETUs by increasing the maximum number of days required for the unit to attain full operational readiness.

X. Summary

With implementation of the new AMEDD, I'd say we met the directives issued by the Army Chief of Staff in 1993 for change to the AMEDD: to attain minimal active duty strength, maintain quality and reduce costs--not only our units, but the total Army population as well. The key elements of the new AMEDD are:

- Creation of deployable ETUs from within the CONUS, active

duty, peacetime health care force structure.

- Implementation of a CAM system to include reserve component personnel with emphasis on primary health care and prevention.

- Creation of a unified health command for all CONUS, area support military health care units.

XI. Conclusion

I hope this letter helps you understand why the AMEDD had to change its way of doing business. We had an excellent system of health care 10 years ago. Back then, we all lived in a simpler and more predictable world. In a real way, the old AMEDD was a *casualty of the peace* it helped create. However, we also have a highly capable and caring Army Health Care System today. Although we depend far more on civilian care providers to accomplish our mission, the AMEDD is still an organization dedicated to providing you with the best, comprehensive peacetime care available. In times of conflict when the AMEDD is again tasked "to conserve the fighting strength of our Army"--maybe for your son or daughter--you can rest assured it will do its job well.

Thank you for this opportunity to respond to your concern.

Sincerely,

Your Senator

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Chain of Command

Military Health Care System

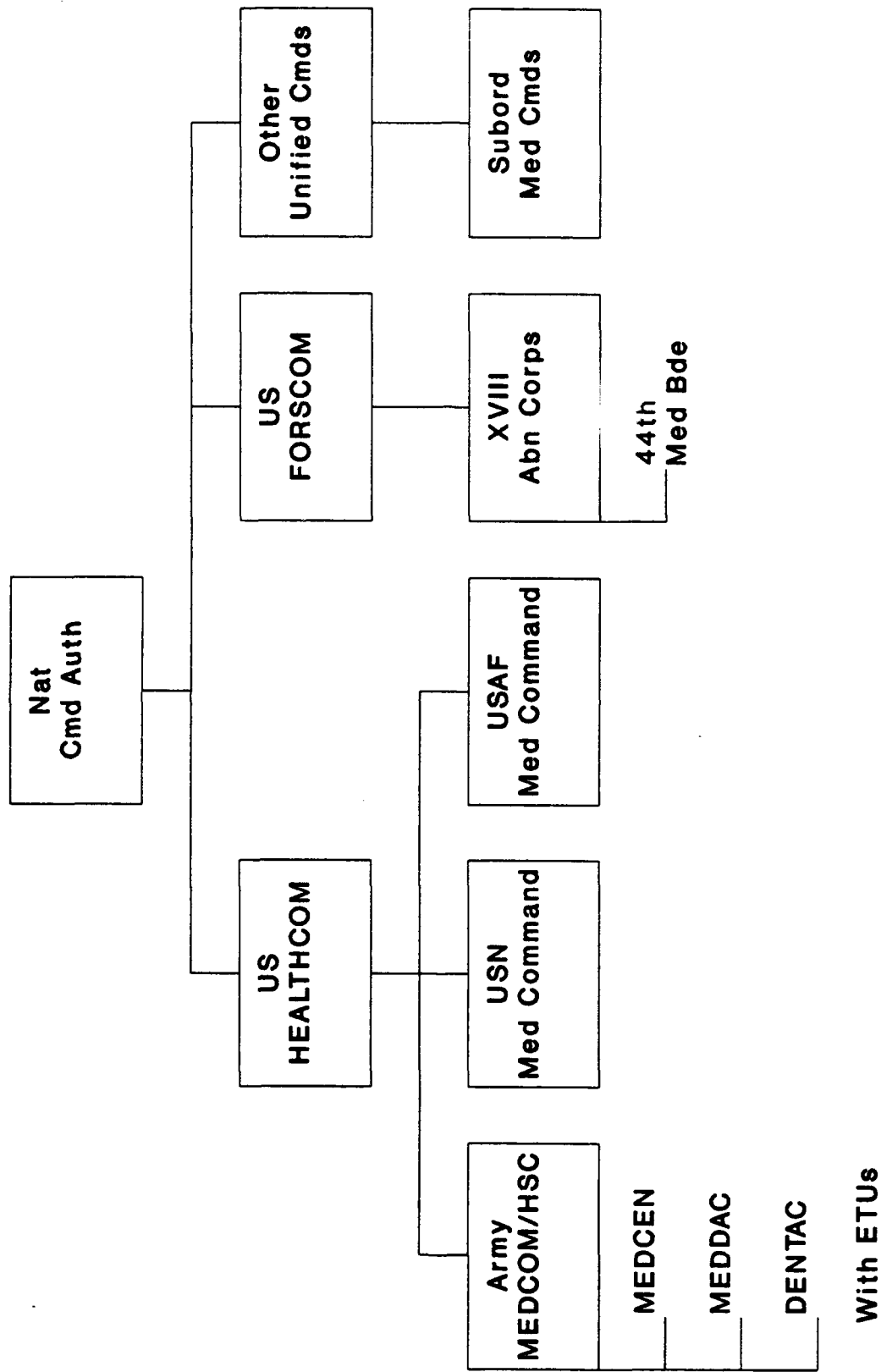


Figure 1